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PSYCHOLOGY IN GENERAL PRACTICE.

Marguerite Stewart.



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During the last twenty-five years a rapid evolution has taken place in medical thought.

From consideration of the physical aspects and clinical symptoms of disease has grown the realisation that illness may sometimes be psychological in origin and that much illness exhibits some psychogenic element. Further evolution of thought is beginning to regard disease as a disorder of the whole personality, and the practitioner of medicine realises that the whole personality must be considered, and readjusted where that is needed, if many of the root causes of illness are to be eliminated.

The privilege of those in general practice is to watch the earliest developments of disorder of body or mind, and the duty of the practitioner includes the recognition and treatment of these early beginnings.

General practice is an art which requires learning. It must be learnt from experience.

At first, fresh from advanced cases of illness in hospital, one is apt to think that many patients

are shams, or are making a fuss over trifles; and one is tempted - like the hero of a well-known novel - to inform them of this and to tell them to "clear out". That is more than failure: it is destructive.

Another temptation is to see the psychological factors in each illness so plainly that one starts investigating these. This, naturally, is resented by the patient. To him or to her the problem is physical, and physical only. On that level we must meet them, win their confidence, stand patiently by, in thorough physical investigations and symptomatic treatment, until the patient is willing for further and deeper help. It may take years; it may take an hour. Help is received most quickly when the patient realises he is bankrupt without it.

No person in normal health visits his doctor frequently. He comes with physical disorder, or with some definite maladjustment to life. Symptoms complained of may be but an excuse for the consultation; whereas the real problem is that the individual has failed to find a motive for life, and is seeking one. Do we not fail them, and our high vocation, if we cannot meet their need, or at least show them where their maladjustment lies?

My experience, for the last seven years, has been chiefly with women in a middle and upper working class practice. Most of them have been running their own homes, or earning their living. A few (300) come under the National Health Insurance Scheme.

In normal times, my partner and I saw from 20 to 50 patients each day, in addition to numerous clinics and other appointments.

From these years of observation and investigation it would seem that the factors most commonly disrupting health are relationships and fear.

The art of learning to live with others in harmony is avoided by many by the expedient of living alone. Others, for whom this escape from a difficult relationship may be impossible, battle with frustration, resentment and fears. Sooner or later physical health is affected, and indigestion, palpitation or other symptoms of psychosomatic disorder may develop.

Psychological methods of treatment are used by every practitioner in one way or another. Which of us is not accustomed to expect restlessness, fret and fear to be smoothed out of faces by the end of a visit?

These helps are necessarily dependent on the personality of the physician. They alleviate symptoms, without offering a cure.

Some natures can be treated by encouragement; by appreciation; by comforting; by suggestion; or even just by friendship. Often with this assistance over a critical period in his life, the patient weathers the storm, and goes on by himself. At other times, to stop short at these alone may be an escape from responsibility for the practitioner.

The following cases illustrate some of the ordinary types that every physician meets, and the methods by which they have been restored to health. Only those of two years' progress, or over, have been included.

Every patient on first appearance is given a thorough physical examination. It is routine to enquire into previous health and heredity; to examine throat and mouth, heart, lungs, abdomen and urinary system; to investigate the reproductive system where there are any symptoms of disorder, and usually examination is made as routine in older married women. This includes examination of the mammary gland. The blood pressure is taken over 35 years, or under that if necessary. The central nervous system is examined.

Investigation of mental history and heredity cannot be done without causing offence. The patient, naturally, feels she has come for a physical complaint.

Where time permits, every new panel patient is given the opportunity of coming up for this general overhaul. About 3 in 10 take advantage of it.

This preliminary examination in itself creates confidence, and it is not hurried, taking from half to three-quarters of an hour. If that is not possible on the first day, it is completed at the next visit. Therefore, in the following case reports, this preliminary physical overhaul may be presumed. Any deviation from normal will be noted, and will have been dealt with.

I. Tacchycardia.

I.C. 1938. A robust, rosy-cheeked youngster of 25 presented herself. She complained of recurring attacks of rapid heartbeating which made her feel very ill at the time.

Physically, the patient was A 1. She had had appendicectomy 2 years previously, and removal of glands in the neck at the age of 4. The heart appeared perfectly normal. Its response to effort was excellent and there was no dilatation.

Psychologically I.C. is immature and unable to take the responsibility a girl of her age should be able to bear. She has a marked sense of inferiority due, partly, to home conditions.

I.C. works in a bank and lives at home ~~with her parents~~ and one brother. Her chief recreation is in training a company of Girl Guides in connection with her church.

The family has now moved to the outskirts of London, and that means much travelling to work and to church.

Her story was that while at work a few weeks previously, she had had a sudden attack of rapid heartbeating. She was seen by the bank doctor and sent home. Attacks recurred. Seen by my assistant, she was diagnosed as "cardiac overstrain" and advised rest.

I.C. had been examined previously, but had always remained rather aloof. When she was visited for appendicitis, the mother did not remain in the room; a sign of incomplete mutual understanding between mother and daughter. Following on the attacks of tacchycardia, however, I.C. was sufficiently concerned to talk freely, in answer to questions.

Yes, she had fears. She was afraid of her father. He had openly said he believed in bringing up his children to fear him. At home she was treated as a child, and felt herself inadequate in her parents' eyes. At the bank, her work was unimportant routine. Escape from this feeling of inadequacy was in Girl Guide activity. Here she was the most important person.

On close questioning, these attacks of tachycardia had appeared within a few days of extra strain, such as the organisation of a bazaar, or extra Guide responsibility, and had spread to lesser strains, such as entering my waiting room.

There was much opposition at home to her Guide work, as it involved extra travelling. She was prescribed Luminal.

The father was interviewed. He was most co-operative, and upset to learn that I felt his daughter's heart attacks were due to fear, and that her chief fear was of him.

It was suggested that she could be helped by encouragement and appreciation; and by treating her as a companion and not as a child; and that the Guide work maintained a necessary balance for his daughter's life.

There were only two more attacks after this. The daughter said: "What have you done to Father? Life is completely different".

The next attack was due to the strain of having to lead the Guide Company song in solo. Through nervousness there was always a false start. She was advised to accompany herself on the piano.

Six months passed before the last attack, when she had gone on holiday alone for the first time. She recently had a tonsillectomy without after results and feels the relationship with the father is steadily readjusting. There have been no further attacks since her summer holiday nine months ago; nor any treatment for them during the last 18 months. Luminal was given for the first six weeks.

Recently, at the end of convalescence from tonsillectomy, she complained of repeated vomiting during the week-end. I said: "Well, what fresh strain have you had during the week-end?" She said: "I became engaged."

This patient has been given sufficient insight to be cured symptomatically, but has not been helped through to a stable foundation. What is meant by this will be made clearer in subsequent case reports.

II. Neurasthenia.

A.E. 1937. A civil servant, aet. 32, arrived from another town. She gave a three months history of "neurasthenia" and had made no improvement during that time.

Organically A.E. was sound. She looked a healthy, open-faced young woman, smiling and not outwardly exhibiting an abnormal mental state. A nurse who lived in the house gave me a report of her emotional instability and fearfulness.

She was not a true depression; but was unable to concentrate at her work. She was facile, sleepless, afraid to be in her room alone at night, and had made no progress in three months. She co-operated readily and insight developed.

Her work was one of responsibility. She lived at home. She and her father had a close friendship, and he shared all his difficulties with her, as they felt the mother was too nervous to be burdened with them. Her relationship with her mother was so unhappy that the patient had numerous evening activities in clubs and societies as an escape. The result was, through overwork and unsolved conflict, she became ill. This disharmony with the mother was the more inexplicable to her as

she and her mother had joined a new church together, and therefore should have been united.

It seemed likely that the mother's attitude was due to a feeling of exclusion and consequent jealousy. The daughter, on her side, had an unrealised resentment against the mother.

The daughter was advised to concentrate on her own wrong attitudes and to leave the mother's shortcomings alone.

She grew to be less self-protective, began to realise where she was wrong, and was willing to reveal herself in letters to her mother. Finally she saw that false consideration for the mother, leading to her exclusion from family worries, was ill-advised.

In three months she was ready again to return to the home situation, and three months later wrote, saying it was marvellous to find life so good, and that she felt fitter every day.

III. Tachycardia; Anxiety Neurosis.

J.M., aet. 49. April, 1937. Previous illnesses - pneumonia and empyema 20 years before.

J.M. consulted me because she had lost confidence in herself.

On physical examination her pulse rate was 120. The heart was not enlarged and the valves were closed. She did not complain of being ill, and would not stay off work.

Psychologically she was emotionally facile, and felt inferior. Altogether she was poor material on which to build.

J.M.'s. story was that she had enjoyed teaching until 1935 when a new headmistress with super-modern methods was appointed. She felt inadequate to work out new methods to the satisfaction of her superior and lost confidence in herself. She was transferred to a new school with a kindly and encouraging mistress and gradually began to recover confidence. She was responsible financially for her old mother and could not afford illness. The following further history was gradually elicited.

The mother, 79, was a dominant old lady who had insisted that the daughter continue to sleep in her room. Any attempts at freedom were met by threats by the old lady that she would leave the home - a hardly practicable threat on the old age pension. She was jealous of visitors; would not allow the daughter to go out; nor would she allow her to help in the flat, as she was too inadequate to be of use.

As long as she was successful at school, J.M. had found in this a happy escape.

Treatment was by encouragement, and by building on any assets she had, and, at first, by bromides. She was encouraged to insist on a separate bedroom; to take more freedom; to see friends. She gradually faced up to the fact that in spite of being a loving and dutiful daughter, she was really resentful with the old lady. She made some emotional readjustments there. Health improved without sick leave, and she discontinued visits after 3 months.

In October, 1938 - over a year later - she returned again, unfit for work and terrified of sick leave alone with her mother. Her headmistress interviewed me. She said J.M.'s. work was appalling. She made no attempt to hold the class, laughed over nothing, was unable to make any decisions, forgot what she was saying in the middle of a sentence and was altogether strange in her manner.

J.M. had also reached the climacteric and had slight flushings and perspiration. Her pulse was 148 p.m.

As the most likely precipitating factor, the home relationship was first investigated.

Apparently the old lady had really been very trying, one of the many democrats who favour dictatorship in the home. The final straw was laid on when the mother got a severe attack of shingles, and told the daughter that it was all her fault, and that her behaviour was killing her. The daughter, being hyper-conscientious, believed this, and the result was an acute anxiety state.

As the daughter's pulse continued over 130, she was put into hospital to have her basal metabolic rate taken and to exclude hyperthyroidism. The mother therefore had to go into a nursing home for old ladies.

Strong reassurance that she could not possibly be the cause of her parent's illness, encouragement that everything she had done was right, and encouragement and appreciation in every direction possible, together with some weeks away from her parent, made a great difference. The B.M.R. was normal. A further period of convalescence took place in a rest home, and in 3 months the pulse rate was under 100.

At her own request, the daughter was not attached to any one school, but put on a supply list of teachers. This meant only temporary responsibility for any one class.

For a year she has continued without further medical attention, able to carry out her duties and to earn her living. Her mental state remains greatly improved.

IV. Rheumatism.

1938. J.M.S., a healthy, highly intelligent young husband, complained of rheumatism. His wife was about to have her first baby.

J.M.S. stood over 6 feet high, in perfect condition, and the rheumatism was confined to the right shoulder joint. Pain was acute, disabling movement and preventing proper rest. There was no obvious arthritis. He was not a rheumatic type, and it was all rather puzzling. After 8 days of ineffective treatment by salicylates, he was asked: "Are you sure you haven't a mental conflict causing this?" He stoutly denied the possibility.

A week later J.M.S. returned. He said: "I'm an industrial psychologist, and I analysed myself after your remark; but I'm too ashamed to tell you what I found as the cause of the rheumatism. It was too humiliating." The rheumatism was cured. J.M.S. is now mobilised and at the front.

V.

X., a boy of 18, confined to bed with pain, chiefly lower abdominal. Watched for some days as a possible appendicitis. There were no objective signs. Feeling confident the trouble was not physical, he was asked: "Is there a particular moral problem troubling you?" He said: "Yes."

He decided to have a talk with his father and, failing help, to meet some other man to whom he could be introduced.

His abdominal symptoms disappeared, and had not recurred two years later.

VI.

Y., a woman clerical worker of 40, in charge of a roomful of girls, had lost her sense of humour and also control of the girls. She came for a certificate of ill-health in order to apply for sick leave. Finally, she appreciated the fact that absence would be an escape and would leave her problem unchanged.

The situation was talked over. Y. made some emotional readjustments, ceased to be sorry for herself, and returned to work. Some months later she returned to thank me. Her difficulties had disappeared.

These last three reports are typical of cases to which brief time has been given.

VII. Headaches; Frequent Illness;
Bronchitis.

K., aet. 44. January, 1936. A borough health visitor.

Previous history included a chronic bronchitis and attacks of asthma. In 1927 she had been treated for 6 months twice weekly by a psychologist, and the asthma had been cured. The psychologist, however, did not feel her treatment was complete. She complained now of constant headaches from the back of her neck through to her eyes, and nausea. She was afraid of doing anything which might precipitate a headache. (This meant she avoided all extra responsibility.)

Clinical examination showed a greyish-faced woman with slightly asthmatic breathing. The chest, too, was asthmatic in type, and there were some medium rhonci. There was no cough. Further clinical findings were normal. She was not climacteric.

Psychologically, K. was markedly inhibited and an introvert.

Previous psychological treatment had cured the asthma, and it seemed likely that the present symptoms were of the same psychogenic nature. The patient was sincere in desiring to be cured. A motive and a plan big enough for life attracted her.

She realised how her life centred round herself, and volunteered that she had often remarked holidays were not long enough, and that there should be a spring and autumn break: so regularly, about the 11th October and 11th March, she would fall ill, and get her holiday in that way.

She began to think and to plan for other people, and her whole personality began to change.

She reports that progress has been steady and health has continued to improve. There has been no sick leave since 1936, and only the commencement of an attack of asthma, the cause of which - fear - she quickly saw, and the attack aborted. Clinically, asthmatic breathing continues, but there has been no cough.

Asked recently if she felt she would have continued to improve without personality change, but with the insight psychological treatment had given her, she replied: "No, definitely. Psychological treatment broke me down and showed me the cause, but left me with nothing until someone came along and showed me a motive for life."

K's medical officer in a verbal report said: "The change in her is remarkable. She was completely self-absorbed and excluded everybody. She could work individually but simply refused to work collectively with other people. She now takes initiative, is willing to organise and definitely seeks to co-operate with people." This medical officer worked in partnership with me over K.

VIII. Mal-de-mer; General Substandard
of Health; Headaches.

F., aet. 48. 1934. A missionary on brief furlough from Africa, asked for attention. She is a bad sailor and the return voyage usually undoes most of the good of the furlough. She is really ill at sea, and has to exist on orange juice. Apart from malaria, her previous health record in the tropics was good.

The patient was sallow and lifeless, with a stoop which made her look deformed. On sitting, she usually curled into strange positions. There was also a vague history of spinal trouble which made walking far an impossibility; therefore, in Africa, she had to be carried when on trek.

Physical examination revealed a low blood pressure, 110/78. Examination of spine and central nervous system was normal. The spine was freely mobile - unusually so for her age - she could straighten easily and the stoop disappeared. There was no scoliosis, deformity nor disability.

Mentally, F's. reactions were slow. It took long for her to express herself. She was worn and discouraged, had no energy and was always tired. I knew she was responsible for the finance of her station and wondered how she forced herself through the day's work.

F. also had a moral problem - the habit of masturbation - which defeated her, and she asked for help to health and effectiveness. Frankly, I had no vision for her, and did not feel much would be accomplished.

F's. mind seemed to work so slowly that it was difficult to know how much was being effected. She did not talk, but just sat, the picture of hopelessness.

Confidence began to return to her and new hope to dawn. She returned to Africa, B.P. 160/105. For the first time there was no disabling mal-de-mer. She was able to stay on deck.

F. reported again 1936. B.P. 112/80. She had had good health during her stay abroad. She still asked for help. This time her brain seemed to be functioning better. The "spinal" trouble was broached. It was a shock to her to realise it was an escape; there has been no disability since.

During this furlough, F. showed unexpected and encouraging initiative. She arrived from the country, suitcase in hand, rang my bell and said: "I must have help. I must stay where I can get help. I can't go back without it." In my dilemma I rang up friends who had never had a missionary in their house, but were sporting enough at once to invite her to stay there. F. owes much to their friendship and co-operation.

Last year (1939) F. reported, looking physically fitter than at the end of previous furloughs - B.P. 120/85. She was alive and radiant, transformed from the lifeless, drab person of 1934. Her work was effective and she was full of the happenings at her foreign post.

As showing how a positive quality of health can be contagious and transmissible, it is appropriate to insert here extracts of a letter from an African leader who came to her desperate, in need, and found spiritual and physical health. He wrote, telling of it:

" My first step was to do something to begin to cleanse my heart of the piles of resentment and worry which lay like bales of blankets locked up there.

"To my utter amazement, I discovered that my spiritual recovery was instantaneously followed by recovery of physical health. For nearly five years before that time I had been at weekly or fortnightly attendance at hospitals, or when I did not trust that treatment I sought relief from a medicine store and spent a lot of money on a large stock of patent medicines. Still good health was far away.

"Since my spiritual change I have never had the need to go to hospital. I have recovered completely and people look at me in wonderment."

F. has returned to her post with yet further health and hope. The sea, still not enjoyed, is no longer dreaded, and there is no invalidism.

IX. Backache; Depression.

July, 1936. B., a teacher, aet. 38, came complaining of backache.

Previous medical history included colitis, tonsillectomy and rheumatism. Two years previously she had dysentery while travelling to an overseas post. The blood was positive to shiga. Her mother had arthritis.

Physical examination was normal.

B. reported a previous attack of lumbago. She had been home six months and for three months there had been backache; but posture or walk showed no indication of it. Examination of the spine gave no result. Pain was vaguely in the sacro-iliac region and was subjective. There was no tender focus. Examination of pelvic organs was normal. X-ray of spine and pelvis and barium enema gave no indication of abnormality. In view of the previous history of lumbago, she was treated by radiant heat and massage. The condition remained unchanged. Diathermy and short-wave therapy were also ineffective, as was medication. She was given a supporting corset. This, she stated, afforded some relief.

Provisional diagnosis was sacro-iliac strain, cause unknown.

Psychologically, B. was a morbid introvert with many inhibitions, and a feeling of inferiority. She never looked one in the face.

From the first, it was evident that the patient was burdened and depressed. There had been an incident on board ship where, she declared, she was taken unaware. On arrival at her destination she found herself pregnant and was distracted as to what to do. As an exchange teacher her career would be ruined. A curettage was performed privately, and now a very active conscience was twice burdened. How could it be right to accept a headship without telling the Committee the kind of person she was. She was almost melancholic and suicidal.

It was felt that only personality change and a new philosophy of life would solve this woman's problems.

It was pointed out to her that she could do nothing about recent events. She could, however, accept a new life and cancellation of the past through the Cross, and receive power to begin again.

B. became as a little child and accepted this new beginning. The cloud began to lift. She

found other things in her life to be readjusted. Resentments and fears began to disentangle, and her keen sense of humour returned.

B. accepted a headship an hour's journey from here by underground, and went to live near her school. From time to time, with longer intervals, she would return (one hour each way of wearying journey) with recurrence of backache; but that was not the real problem.

I am sceptical as to the severity of the backache. It seemed to come and go according to her spiritual state. The corset, of professed value, was usually forgotten, or required mending, or there was some other reason for not wearing it. Two hours of wearying travel are also not lightly endured with a backache, and psychologically there was no transference to encourage her to come. Each visit meant time given to unearth the problem from which backache might be the escape. There was often some relationship wrong with the staff. This required adjustment. Finally the real problem was admitted. It was masturbation, a habit which defeated her. With victory and release over this, B. has discontinued visits. She is in touch with another physician nearer who has co-operated in helping her on the same lines.

This history brings out a point of importance: what to do with a patient who has an acutely burdened conscience and is suffering from moral defeat. To soothe that conscience by assurance that defeat - a habit which cannot be broken - is of no consequence and need not worry him, does not deliver the person from feeling inferior. He feels more than ever degraded at being asked to acquiesce in a standard lower than the highest at which he aims.

In the last seven years, about a dozen people have come with this problem of moral defeat through masturbation as their only or chief complaint. One young girl who seized the opportunity to come to a woman doctor while her own, a man, was on holiday, burst into tears in the consulting room. The problem had to be dealt with and solved before investigation of the vague abdominal pain she complained of could proceed. She has had complete release from the habit ever since.

In two other cases, physician or clergyman had tried to soothe conscience, and this seemed to have made these two feel even more degraded and more desperate. Victory was won through co-operation in personality change. The whole personality had to be redirected for any part to be set free.

In only one case was there failure to find liberty. This was a white-haired woman who was also a pervert, but not deeply concerned about it. She had short periods of remorse, however, during one of which she first came. Unfortunately she was unwilling to co-operate and finally ceased to attend.

The same method of bringing release is used for those chained to other habits, including addicts. (Case xix)

X. Insomnia; Indigestion; Lack of Energy.

March, 1938. N., a book-keeper, a mature, capable woman of 40, came for treatment of leucorrhoea.

Physically, the patient was a robust, well-built, florid type and had never been a week in bed except at the birth of her child, three years before. Leucorrhoea dated from that time.

N. was tense, unhappy, and her confidence was quickly gained because she was so desperate. Three years previously her fiancé had committed suicide. He had confessed he was a married man, and her baby was now three. Since that crisis she had felt "run out", lifeless, with no motive for living or for work. She was sleepless and had indigestion and heart-burn.

Relationships in the home were difficult. Her mother, with whom she stayed, was a dominant, hard individual whose word was law, and who used the past as a lever to obtain submission.

The baby was so nervous that it did not go to sleep until 10 p.m.

Business relationships, too, were unhappy. She worked for a refugee, an orthodox Jew. She felt her position insecure; was distressed at certain methods of business; but afraid of being dismissed and out of work if she spoke about them.

It was suggested to her that the problems affecting the temperament of her employer were those responsible for her own state of health, namely, resentment, fear and insecurity. If she found the answer to these in her own life she could help him. She suddenly saw this. Hope began to dawn. Finally the caring of God became real to her, and the forgiveness of sins.

She found the answer to her own crippling problems and began to plan constructively how to help her employer with his difficulties.

Now that she was readjusted to life, fear and resentment left her. She discovered, too, that the physical symptoms of insomnia and indigestion had

also disappeared. More than this, her little girl began to lose her nervousness and went to sleep at 8 p.m.

With both of them improvement continues. The child now sleeps at 7 o'clock.

In the office, conditions began to be different as a result of her new outlook. Two brothers who had not spoken for years are now on good terms with one another.

Business methods have altered. It is now possible to work without a feeling of lowering one's standards.

The home situation has improved, but requires further readjustment. There is freedom for her to go out during daylight hours. N. still has fear of her mother and is facing this problem. As she is not allowed out at night, or before the child is asleep, she is seen too seldom to get the help she still requires. The reason for this imprisonment is interesting. The family is terrified of possible air raids - the mother has not left the house since September - and N. realises she is to them a bastion of security, and they are afraid to be left.

This case demonstrates what is true also of most other patients who have been helped through to a real personality change - that those with new health, not only of body, but of the whole personality, seem to have the power to alter the situation around them. Plenary health appears to be transmissible.

XI. Phobias; Migraine; Colitis.

H., aet. 35, a typist in the civil service, rosy and perk and full of self-interest, attended for three years with physical complaints before her confidence was gained. She was afraid of confessing to the stupid fears which bound her in case of being misunderstood and laughed at. She was also annoyed at seeing the junior partner instead of the senior. Finally her fears - fears of going out alone, of travelling by bus or tube - so paralysed her that she was unable to go to work.

Physically H. had a poor heredity. Her mother died of pulmonary tuberculosis when she was nine, and the father when she was twenty-one. She had frequent colds and laryngitis and her throat was

often infected. She also complained from time to time of nausea and heartburn; she had severe and recurring headaches and migraine and had bouts of diarrhoea. Repeated physical examination did not reveal any serious lesion.

Psychologically H. was immature and unambitious - more like 25 than 35. From earliest age she was afraid of being left. She was afraid when first left at school. Her chief security in childhood and adolescence was her father. To encourage her to break through fear, he would bribe her to run out alone on errands.

The father married again, but relationship with her stepmother was very strained, and at 21, when the father died, she was turned out of the house.

H. went to live with an aunt and uncle, and was so grateful to be given shelter that she submitted to a rather possessive relationship.

After her father died, fears of going out alone disappeared for years. She was not happy with the aunt. Until recently she was not allowed to take friends to the house, or, if they came uninvited, to see them alone. The aunt gets bronchitis, and H. is afraid of coughs and afraid of being left alone in the world, though she has many relations. She is

afraid of the aunt; yet the aunt represents security, and she is afraid to leave her. Two years before she would confess to them, her previous fears returned and increased.

It was felt that the best hope of helping H. was to give her a wider philosophy of life, and a security that was permanent. She was willing to co-operate.

She was introduced to another patient who had found the answer to fear through a living faith.

H. was so grateful to find someone else who had had fears and was not ashamed to own to them, someone moreover who had lost her fears, that hope and faith were born. Readjustments had to be made in her own attitudes, resentments faced, apologies tendered. H. discovered what rebirth stands for and felt new power come into her life.

In a few weeks she was back at work, able to travel without strain.

H's. progress was interrupted. She caught a chill and developed an acute colitis, necessitating hospital investigation and treatment. Treatment required to be unduly prolonged, and at last it was felt that this was yet another escape. Escape from what?

XII. "Neurasthenia"; General Debility.

M.M., aet. 42. 1933. Physically - slight in build, organically sound, but listless.

Psychologically - appeared self-absorbed, resentful and full of self-pity.

For months, weekly certificates with "neurasthenia" as a cause of illness had been signed. When seen, the patient complained of being unfit for work, of being unduly tired, and of not being able to face work. Her whole demeanour showed resentment and self-pity.

Certificates continued to be given until the patient's confidence was gained, and hope and interest aroused.

Apparently M.M. had been assistant matron at a holiday home. There she felt her rights were slighted. She took offence at what she thought were indignities, and considered she should have been treated more as an equal and less as a menial. Finally, to crown her resentment, she was dismissed as incompetent.

Visiting us was a patient to whom hours of time had been devoted, and who now was sufficiently free of her own similar crippling problems to be of use in helping others. They were introduced, and a personality change began in M.M. She became readjusted to life. Health improved and in a short time she found a new post. Since then she has continued at work, giving satisfaction and earning commendation. Life no longer revolves round herself and she has ceased to be a problem to her physician and a burden on the community.

XIII. General Ill-health; Migraine;
Indigestion.

E., aet. 48. 1935. A college lecturer came to unburden herself because she felt so ill and so unhappy. Previous history included pneumonia at 17; indigestion always and for years; acid eructations, nausea and vomiting and frequent attacks of migraine. She also had insomnia and was always tired. There was constipation with occasional bouts of diarrhoea.

Physically, E. was tall, thin and highly-coloured. Blood pressure was 100/85, but clinical examination did not reveal adequate cause for her symptoms. Appendicitis was twice suspected, but a surgeon who saw her diagnosed migraine. Menopause occurred two years later.

Psychologically E. showed a marked inferiority state. She was inhibited and indecisive. She had always taken an active part in church life; but lately religion had seemed flat.

E. had arrived at a crisis in life frequent in single women over 40. She looked back with regret on past opportunities when she had refused marriage. She realised suddenly that life would no longer unroll before her.

An emotional disturbance in the shape of a passionate friendship with another woman was arousing desires and disturbing dreams. She wanted to call a halt but could not.

To unburden gave her great relief. She felt it a definite step forward, and the unhealthy side of the friendship disappeared. What was said I have entirely forgotten, and so has she.

Digestion greatly improved and has not required treatment. Attacks of migraine occur infrequently, and she can always trace a cause. Insomnia disappeared and general health is much better. In addition, E. was able to reduce the change that had remade her into practical steps and to transmit the help she had found to others. Among these is her cousin G. who is reported later.

E., as college lecturer, reminded me of two students, D.H. and J.H., sisters who had come as patients, and remarked how completely different they were now. So it may be of interest to include a brief account of these cases.

XIV. Nocturnal Enuresis.

J.H., aet. 18. 1934. From the age of two, dating from the birth of her younger sister, there had been frequent nocturnal enuresis. This prevented her joining in camp life or from going to a residential college. She had been treated by several excellent local practitioners without result.

Examination revealed no cause for the lack of control. She was otherwise healthy. The mother was very neurotic, but ambitious for her daughters.

Before sending J.H. for an examination by a specialist, it seemed worth while to examine the psychological side of the case. The daily routine was investigated, any exciting factors eliminated, and what religious faith she had (the mother had none) was reinforced by strong suggestion that through it she would find victory. Confidence returned to her, and in a few weeks she became perfectly normal and has continued so. Any lapses during those early weeks were traced to some exciting factor. The relationship between these and her enuresis was shown her.

There has been no further failure. She leads a perfectly normal life.

XV. Frequency of Micturition; Claustrophobia.

D.H., aet. 19. 1937. The sister of the previous patient came three years later. She had been at a residential school where the pupils were educated in a strict evangelical faith. (J.H., the sister, was Anglo-Catholic.) From school, D.H. went to a training college. Her lecturer (E.) reported that she was a mass of nerves and a troublesome student, but popular with other girls. She left college to take up a post as teacher in an elementary school, and was able to live at home.

D.H. now found, to her despair, that she, too, had developed bladder symptoms. She had to run out of class several times every hour. She also had mild claustrophobia, and dreaded travel by bus or underground. At this point she came for advice.

Organically D.H. was sound. There was no cystitis.

Psychologically the home background was limited: the father was a labourer; the mother neurotic, with no religious faith. She considered her daughter's evangelical outlook narrow and stupid, and tried to alter it. The girl had an upheaval in spiritual life, as she found opposing beliefs at home and at

college, and realised, too, that her own faith was theoretical and untested.

It seemed wiser for the daughter to live away from home until she had reached some spiritual stability.

In treatment D.H. began to realise the negative factors at work, and how to meet them. She became completely cured and is now normal, and is able to live at home and to travel.

The lecturer (E.) meeting her a year later, commented on the remarkable change that had taken place in her whole personality.

XVI. General Anxiety State; Tacchycardia.

G., aet. 42. March, 1936. G. came complaining of menopausal symptoms - flushings and perspiration.

Physical examination showed a quick pulse of over 100, but otherwise was normal, except that the patient looked worn and older than her years.

Psychologically G. had a strained anxious expression. She was full of fears - fears of insecurity, of ill-health, of the future - and seemed to be suffering from a general anxiety state.

Injections of ovarian extract alleviated the menopausal symptoms, until these ceased after a few months' treatment.

From a cousin (E.) it was learnt that G's. background had been difficult. She was the kind of soft-natured person of whom people would frequently take advantage. She had been dominated at home; there had been a broken engagement; now G. had to try to augment her parents' tiny income. She was acting as housekeeper and was greatly overworked. With all this good nature and softness, there were also resentments, self-pity and frustrations.

G's. anxiety state continued, and finally she was referred to a specialist and admitted to hospital as a probable thyrotoxicosis. Her basal metabolic rate was normal, however, and she was transferred to another hospital to which a psychotherapist is attached.

This psychotherapist gave a poor prognosis as to her anxiety state, and doubted the possibility of the patient's being able again to earn her own livelihood. She was discharged, condition unchanged.

G. returned to stay for a short time with her cousin (E.) (reported previously). This cousin was able to co-operate in passing on the experience of personality change that she herself had found.

G. discovered a new security, and found peace in a wider philosophy of life and in a personal faith.

Her resentment and fears began to go. Tacchycardia disappeared. She continued to improve and is now able to stand, spiritually and mentally, on her own feet. She has had to return to the difficult home situation to look after her parents, but reports herself as continuing well, and her cousin confirms this.

XVIII. Frequent Ill-health; Bronchitis;
Rheumatism.

W., aet. 40. 1937. A tracer in an engineering firm was continually indisposed. She had frequent bronchitis or rheumatism, and was lonely and unhappy. One day, when she summoned her busy physician, not, as she explained, because she really required a visit, but because she was depressed, it was felt some radical treatment must be attempted.

Five years previously there had been hysterectomy for fibroid. Every winter there were coughs and colds; she was continually attending for treatment.

Physically, apart from this low resistance to colds and the recurring arthritic pains, W. was organically fit.

Psychologically, the patient was inferior, fearful, with fears of insecurity, of the future and of old age. She had always earned her living. Her younger sister, of whom she was jealous, had been spoilt and petted at home and never trained to work. Nevertheless, the younger sister had secured a husband.

The practice was very heavy at that season of the year, and it seemed impossible to give her the time she required. She was asked if she would like to meet another patient who had found the answer to fear. She agreed to this.

W. found plenary healing. Her mental and physical condition improved, and for over two years she had no bronchitis nor rheumatism. This winter

again came the old complaints, cough and debility. What was the underlying cause?

Once general health had improved, and she had found a personal faith, W. ceased to co-operate. She remained friendly, but felt it unnecessary to co-operate with others in team work or to redirect her energies outwards. She attended church enthusiastically, but the help she got was kept for herself and her own spiritual enjoyment.

The sister meantime had separated from her husband, and now shared a flat with W. The sister was lazy, did not make a home, or even do her share of housework. She was provocative and mocked at W's religious faith. The latter became resentful, full of devastating self-pity, and quite lost her sense of humour. She came for help.

W. faced up to her conflicting emotions. She realised that what her sister said or did was unimportant. It was her own attitude that was affecting health. She apologised for her side of the blame, and met in so doing an unexpected response from the sister. She realised, too, her previous selfishness, and decided to co-operate with others.

With these new steps W. is physically restored and psychologically released.

This case demonstrates what is seen so often, that progressive health seems to develop best when the individual is working in co-operation for others, and with energies redirected outwards.

Two weeks later W. remarked that although she had been a heavy smoker, this habit had been entirely broken without strain.

XVIII. Claustrophobia; Rheumatoid Arthritis.

H.L., aet. 53. 1934. As relevant to present conditions, this case may be included briefly.

H.L. is a granny of 58, crippled with rheumatoid arthritis in hands, feet, shoulder and neck; but she has an undaunted spirit. Her husband is a retired teacher.

On physical examination blood pressure is 105/60. In addition to arthritis, she has angina pectoris. The mother died of angina.

During 1914-18, H.L. had a mental shock through the behaviour of someone dear to her, and an attack of neuritis followed this. During an air raid she was in a bank. Everyone was pushed into the strong room and the door shut. She developed panic as to the possibility of never emerging, and afterwards found herself afraid of closed spaces, could not enter a lift, or even remain in a room with the door shut. She told no one, and managed to hide the fact.

In 1920, at 43, rheumatoid arthritis commenced. A specialist told her she would be crippled at 50. She fought against this horror and disability by all kinds of treatment for $12\frac{1}{2}$ years, and spent all her savings. She then heard of plenary treatment and came for an interview. For some weeks there was no free time to give her, and she was helped by a young medical student to whom she owes much for the personality change that began.

Worry, fret, fear and rebellion disappeared. She found peace and decided to stop all treatment for the arthritis. One hand, the most crippled, has so improved as to be normal in function. The other hand, feet and shoulder are improving. There has unfortunately been spread of arthritis to the neck, following an accident.

What is noteworthy, however, is that she finds, to her delighted surprise, that the claustrophobia of 20 years' duration is cured. She can go in lifts and live within shut doors.

Recently H.L. was severely concussed through falling down a twelve foot area in the darkness. She has recovered well and is anxious to test whether it has affected her freedom from claustrophobia.

This patient is a centre of stability and wonderfully successful at passing on the secret of freedom from fret and worry, and the adventure of life.

Age seems no barrier to plenary treatment.

XIX. Morphia Addiction.

As final report, this case of morphia addiction will be given briefly.

P., a woman of 48, came seven years ago for alleviation of severe menopausal symptoms. In addition, she was inhibited, melancholic and desperate. Confidence was exceptionally difficult to win; but treatment for her mental state had to be attempted to prevent tragedy. Expert help was refused and she ran away from two psychotherapists....

A morphia addiction of twenty years duration has been vanquished. Once in those twenty years, she was deprived of the drug for two years; but spent most of the time weeping, unable to work. The average total of daily injections must have been about two grains, and she has not touched it for 6½ years, since she began to co-operate in personality change, (a last forlorn hope).

The family history includes four suicides, and the patient appears to be a ^{case of} chronic melancholia, with deeper phases of depression.

During those early months P. continued at work, except for two weeks in bed, and at first there were anxious days when risk of suicide was present. She is in a hard executive post; depressive phases now recur infrequently and are less severe, and her

personality has changed greatly.

This case is not presented as a cure yet; for, in the deeper phases of depression, temptation to relapse still recurs.

A harder fight than sudden cessation of the drug habit seemed to be the breaking of a homosexual relationship with a woman of strong and attractive personality. The strain of that, too, has finally gone. There has been no transference onto the physician.

These cases give a review of some of the diverse problems confronting the general practitioner.

DISCUSSION ON PLENARY TREATMENT.

This method of working, by consideration and treatment of the whole personality, has become so natural that work on any other basis would be strange. It is difficult to realise that it is not the general way.

Not all who present themselves as patients are aided by psychological means. Through lack of time and suitability cases must be selective. Nor are all patients thus selected treated so fully as in the cases recorded: whenever the way opens naturally to do so, and the patient wishes it, further help is given. Hardly a day passes when this is not possible to some degree. It may be necessary to see the patient frequently.

An advantage of panel practice is that one can see patients as often as is necessary to establish confidence without committing them to financial strain. The advantage of a dispensing practice, such as is the usual custom in the south, is again the opportunity of seeing the patient more frequently than would otherwise be probable.

The great handicap in working by aiming at plenary treatment is lack of time in a busy practice. As will be noted, the cases recorded are of those who

asked for help or were so desperate without it that to leave them would have been cruelty. In the last three months of 1939, when three-quarters of the patients had evacuated, leaving time for the rest, more people were helped through to a real personality change than in the previous two years of very heavy work. One of these, a woman of 42, responsible for a business, who was an anorexia nervosa, but now, to her delight, looks forward to meals with appetite, asked why I had not given her this help years before.

As diagnosis is first necessary before adequate treatment for illness can be offered, so in the production of plenary health it is important for the physician, for the purpose of selection, to be able to recognise the signs of conflict and the symptoms of personality disorder even before confidence is won.

Discernment into personality problems grows keen with experience, and one can often tell at the first interview where maladjustment lies, although little may have been said.

Modern knowledge of physiology and psychology teaches us the effect, through the sympathetic-parasympathetic autonomic nervous system, of primitive emotions such as fear, hate, greed or jealousy, on

the digestive system, the endocrine glands (and on blood chemistry), on involuntary muscle tone and on local blood supply. How can the sympathetic-parasympathetic balance be maintained, emotional control be instituted, and the forces of goodwill, confidence and peace harnessed for health, instead of those emotions which upset physiological harmony?

It is these deeper, root causes of imbalance which, in this thesis, have been called personality problems. In the maintenance of health, a cure for these must also be found through the medical profession.

That this cure can begin and be progressive has been illustrated by typical cases. It seems apparent that only a change in the patient's personality will suffice. This has already been referred to as going deeper, in some ways, than psychological help, and as establishing a stable foundation for health. Let us define it more clearly.

By therapeutic personality change is meant a process which involves a redirection of life onto the highest moral level; the realisation of a purpose and a plan for the individual and for the community; determination to fit into this plan; and the acceptance of spiritual illumination, inspiration and power both to begin and to continue living on this basis.

Through illumination, the negative factors at work in the individual are gradually recognised by the person, and he is helped to deal with them. Thus, change is progressive. Through inspiration, direction is sought for daily living, and for a part in a plan for the community. This provides adequate sublimation and a motive for life, outside self-interest, and big enough for all.

Spiritual power claimed and experienced releases the individual from the strain of self-effort in living up to his ideals. The acceptance of an inner discipline, constantly practised, develops this new outlook on life into a daily habit.

What are the requirements of the physician for the technique of this deeper therapy?

To begin with, he must know through personal experience the road along which he would lead the patient. As in psychotherapy an analyst should himself first have been analysed, so in therapy for personality change the physician must know the answer to fear, resentment, pride and prejudice, or any other disintegrating factor, before he can help his patient through to plenary health.

TECHNIQUE OF TREATMENT.

Establishment of confidence is essential to treatment. This must go deeper than the usual confidence placed in the family physician by the patient, but does not imply psychological transference. Such transference is avoided. Where such a relationship might readily develop, it is a sound policy to have co-operation in treatment (Cases XI, XII).

In pure psychological or psychiatric practice, the patient comes realising the type of help he is going to receive, and usually appreciating his need of it. He is willing therefore to co-operate in greater or less degree by frankness about his troubles and his background. He also does not resent the physician's probing tactfully into the past.

In general practice, on the other hand, the patient clings to belief in a bottle of medicine to such an extent, that for all ailments, even for a fracture, the majority demand medicine. (This holds true at least in this suburb.) The approach to psychological treatment by the practitioner must therefore be different from that of a psychologist; it must be by way of physical symptoms, and it is a greater triumph for the physician when a clear history is obtained and co-operation won.

The establishment of confidence for this co-operation is sometimes at a cost. It means real caring for the person. It may even have to be gained by bridging the gulf of superiority between the donor of help, the physician, and the recipient, the patient. By this is meant approach on a basis of frankness, where the physician, realising the deep need of the other, is willing to admit he too has had fears, failures or other maladjustments in his life, and to indicate how these were solved. This is in opposition to one's education which was, "Never give yourself away to a patient"; but it has been the only way sometimes to win confidence, to encourage honesty in the other, and to stimulate hope and vision, and belief in the efficacy of a new beginning. Moreover, trust on this basis does not seem to produce more than a slight and passing transference. The one difficult transference there has been to handle was where the foundation for treatment had not been established in this way.

Confidence won, then comes the real difficulty: how to proffer help so that the patient will accept it.

Healing begins when the patient develops insight, recognises the emotional conflicts within him and reduces them to concrete reality by admitting what they are. For instance, fears are reduced to fear

of financial insecurity, fear of being hurt, fear of taking blame. Self-consciousness is shown to hinge on pride, while resentment and greed proclaim a demand basis of life rather than life lived on a basis of unselfish, constructive contribution to one's fellows and to the world.

Next comes the decision by the patient to co-operate in this new beginning. He must take definite steps, and sincerity is shown in willingness to adjust in a positive way what was wrong in the past. This may be by making apology or restitution where that is needed. From this comes a salutary feeling of confidence which helps to dismiss the past as a negative factor in health. Positive qualities replace the destructive tendencies.

Thirdly, inspiration and power are sought for daily living. Further illumination reveals more negative forces at work within the individual and these must be dealt with. Personality change thus becomes progressive. The patient learns how to tackle his difficulties and this leads to stabilisation and independence of the physician. To this end, and as an important part in the maintenance of cure, the patient is linked up with others who have been similarly helped through to personality change and who have found an adequate objective in life.



This team work through co-operation of past patients is invaluable as a stabilising force. In early days, when there was no such team, one had to invite all wanting further help to come together once a week as there was no time for individual talks. Finally, as many as twenty at a time gathered like this. Many of that early team are now taking responsibility for the welfare of others, and the most recently helped, who still require stabilisation, meet here in small groups of three or four people. These also meet in co-operation with others: thus dependence on the physician is prevented.

Plenary treatment should be possible by every physician. The completeness of such a therapy for physical, mental and spiritual health, will prevent much illness of body or mind; and this has a direct bearing, in times of national emergency, on the maintenance of personal and national health and morale; for the problems of the individual - relationships, greed and fear - are those of any community. The person with the answer to these in his own life becomes a national asset.

S U M M A R Y.

1. This thesis has shown the importance of treating illness as a disorder of the whole personality.^{1, 2, 3, 4.}

2. The effect of emotional and environmental factors on the psycho-neuro-endocrine³ system is demonstrated by typical cases. These factors include fear, self-indulgence, unhappy relationships, resentment, worry, frustration and inferiority.

3. Alleviation of symptoms by drugs alone is but temporary cure.

¹.Halliday: The Psychological Approach to Rheumatism; Proceedings of the Royal Society of Medicine, November 19th, 1937.

².Halliday: Psychological Factors in Rheumatism; British Medical Journal, January 30th, 1937, p. 213, and February 6th, 1937, p. 264.

³.Halliday: The Rising Incidence of Psychosomatic Illness; British Medical Journal, July 2nd, 1938.

⁴.L.T. Swaim and Harris (1938): Proceedings of the Congress on Rheumatism.

4. Root causes must be handled constructively for cure to be effective.

5. Therapy is shown to be most complete when it includes personality change. This may be called plenary treatment, and by it disrupting emotional factors are replaced by positive, health-inducing forces. Confidence replaces fear; creative activity releases frustration. (Cases VII, VIII, IX, X, XI, XII, XIII, XVI, XVII, XVIII.)

6. Personality change is defined as a new illumination, inspiration and power for the redirection of life. From this issues a freedom from mental conflict, and energies set free are directed into channels that are creative and purposive for the individual and the community.

7. The new quality of health thus attained is more than the absence of disease. It is the "presence of a moral and spiritual foundation for life"¹ and is transmissible. The patient becomes a positive force in the community. (Cases VIII, X, XIII.)

8. Aid to partial personality change may be of value. (Cases I, II, III.)

¹. Medicine and the Present Emergency; British Medical Journal, August 5th, 1939.

9. In the establishment of cure, the value of co-operation by past patients, and the redirection of the patient's energies into creative planning for others is illustrated. (Case XVII.)

10. Reference is made to the handicap of limitations of time in working along these lines in a busy practice.

11. The importance of such work in the prevention of mental and physical ill-health, and its bearing on national problems, is noted.

12. The availability of this method of therapy for every practitioner is stressed; and the equipment and technique for plenary therapy are discussed.